Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOWARD DILLARD, MD
3100 TIMMONS LANE #250
HOUSTON, TX 77027

Respondent Name

HARTFORD INS CO OF THE MIDWEST

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-3224-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: As stated on the Table of Disputed Services: "Injured worker not at MMI. Per TDI Reference Guide, if injured worker not at MMI, do not conduct IR Exam. Please see attached supportive docu."

Response Submitted by: The Hartford, 300 S. State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 02, 2010	99456-W5-WP	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes: Explanation of benefits dated July 26, 2010
   - W1 – WC STATE FEE SCHED ADJUST. REIMBURSEMENT ACCORDING TO THE TEXAS MEDICAL FEE GUIDELINES.

Issues

1. What Designated Doctor (DD) services did the Division order?
2. Is the requestor entitled to reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor (DD) was asked to perform an examination for Maximum Medical Improvement/Impairment Rating (MMI/IR) and Return to Work (RTW) by DWC via the EES-14. The RTW billing was paid and is not in dispute. The requestor billed $650.00 for an examination using CPT code 99456-W5-WP. Documentation supports that the injured worker (IW) was not at Maximum Medical Improvement (MMI). There is no support for an IR and an IR is not performed when the IW is not at MMI. Upon review, the requestor also failed to use proper modifier –NM for billing this exam when the IW is not at MMI as required by 28 Texas Administrative Code §134.204(j)(2)(A) states:

   (2) An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title.

   (A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

2. The respondent chose to reimburse an amount of $350.00 for the determination that the injured worker was not at MMI even if modifier usage was incorrect. There is no IR. Therefore, the requestor is not entitled to any additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 02, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.